WASHINGTON Link4Health

COMPARISON: CLINICAL DATA AVAILABLE FROM PATIENT ELECTRONIC HEALTH RECORD TO CLINICAL DATA REPRESENTED IN CLAIMS

Data Population Strategy:

- Leverage increased availability of more granular, clinical information direct from a patient's electronic chart currently held within a providers' electronic health record system.
- Provider expected to provide clinical summary through a standard electronic transaction to centralized Clinical Data Repository (CDR) each time they see a Medicaid patient.

Data Collection and Sharing Method – Continuity of Care (CCD)

- Universal standard set of high value clinical data about a patient's healthcare, covering one or more encounters. Provides snapshot in time of clinical, demographic, and administrative data for a patient.
- Contributes to longitudinal health record in a centralized CDR for access by different authorized health care providers.

Description		Represented in CCD	Represented in Claims
Timing	Age of the data	• Near Real Time • On demand by request/query and response • Triggered by pre-set events (Medicaid patient seen)	• During billing cycle up to 1 year • Modifications for up to two years • Pharmacy data near real time
Purpose	Reason for which the clinical summary was generated,"	• Response to query by qualified health care organization or provider for transfer of patient, referral, patient request, etc.	• Reimbursement for services covered and present if service is being billed for.
Conditions	Lists and describes all relevant clinical	• ICD code[1] that describes diagnosis • Range of time for which problem was active	• ICD code that describes diagnosis

[1] ICD codes (International Statistical Classifications of Diseases) are alphanumeric designations given to diagnosis, description of symptoms and cause of death.

Description		Represented in CCD	Represented in Claims
	problems and conditions for which the patient is receiving care. Conditions are broader than, but include diagnosis.	• Level of medical judgment used to determine problem • Text description of problem suffered • Provider treating patient for condition • Age of patient at onset of condition • Indication if problem was one of the causes of death • Age of patient at death	
Procedures	Defines all interventional, surgical, diagnostic, or therapeutic procedures or treatments pertinent to the patient historically.	• CPT Code[2] that describes historic procedures • Date and time of all procedures, including duration • Identifies provider performing procedure • Text describing procedure or indication if patient opted not to have a recommended procedure	• CPT Code that describes procedure being billed for • Date of individual procedure being billed for • Identifies provider performing procedure • May include short comment by billing staff
Family History	Contains data defining the patient's genetic relatives in terms of possible or relevant health risk factors that have a potential impact on the patient's healthcare risk profile.	• Family member demographics, health history, genetic test results; relationship to family members • Free text data entry for relative to note special cases • Name of family members • Data of birth of family member • Family member gender, race and ethnicity • Family member condition • Age of the family member at onset of condition • Indicator if condition was cause of death • Age of family member at death • Identifies type and date of genetic lab tests	• None

[2] CPT (Current Procedural Terminology) code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, and payers for administrative, financial, and analytical purposes.

Description		Represented in CCD	Represented in Claims
Social History	Defines patient's occupational, personal, social, & environmental history with potential impact on patient's health.	• Type of social history – smoking; alcohol or drug use; diet; employment; toxic exposure; exercise • Severity - number of units; times; frequency • Range of time social history was active for patient • Text description of the social history	• Code for smoking, chemical dependency
Payers	Describes payers and the coverage they provide for defined activities.	• Define entity responsible for payment of patient care • Payer data needed to bill and collect from • Authorization information for patient or provider • Patent's current payment sources	• Define entity responsible for payment of patient care • Payer data needed to bill and collect from • Authorization information for patient or provider • Patent's current payment sources
Medications	Defines patient's current medications and pertinent medication history. This includes the patient's prescription or non-prescription medications and medication history. Includes medical condition or problem intended to be addressed by the ordered product.	• Product Name • Identity of Prescriber • Quantity ordered and order expiration • Order date and time • Ordering provider • Prescription number • Pharmacy that dispensed medication • Date and quantity dispensed • Fill number and status – complete; never picked up • History of dispenses for this order • Medical condition to be addressed • Intended or unintended effects • Type of Medication - prescription; over the counter • Status of medication - active, chronic, acute • When to take medicine – blood sugar > 250mg/dl • Text of instructions from ordering provider to	• Product Name • Identity of Prescriber • Quantity ordered and order expiration • Order date and time • Ordering provider • Prescription number • Pharmacy that dispensed medication • Date and quantity dispensed • Fill number and status

Description		Represented in CCD	Represented in Claims
		patient • Indicates when medication to be stopped or tapered • Timing, frequency and intervals to take medication • How medication is received – mouth; IV; topical • Maximum dose and or duration • Product form – tablet, capsule, liquid; ointment	
Advance Directives	Defines patient's advance directives and any reference to supporting documentation.	• Contains advanced directive type - living wills; healthcare proxies; CPR; resuscitation status • Effective date of advance directive • Custodian of the document – person; organization • Text to describe advance directive type	• None
Alerts (Allergies, Adverse Reactions)	Lists and describes allergies, intolerance conditions, severity, adverse reactions, and alerts pertinent to the patient's current or past medical history.	• Date allergy or intolerance was known to be active • Type of product and intolerance suffered – medication; food; environment; other • Name of product or agents that causes intolerance • Description of the reaction • Description of level of severity of allergy or intolerance	• None
Immunizations	Defines a patient's current immunization status and pertinent immunization history.	• Code describing the product • Name of the substance • Person who administered immunization • Flag indicating immunization event did not occur and nature of refusal (patient refused, adverse reaction) • Date and time administered or refused • Indicates which in a series immunization	• Code describing the product if being billed for • Name of the substance • Person who administered immunization

Description		Represented in CCD	Represented in Claims
		represents • Intended or unintended effects or reaction	
Medical Equipment	Identifies all pertinent equipment relevant to the diagnosis, care, and treatment of a patient.	• Code describing all pertinent equipment a patient's health is dependent on – implanted; external; • Medical condition to be addressed • Intended or unintended effects • History of medical device use • Supply quantity and number of fills	• Code describing equipment being billed for
Vital Signs	Contains all vital signs for period of time summarized, but at a minimum includes notable vital signs such as the most recent, maximum and/or minimum.	• Identifies the type of vital sign observed – blood pressure; heart rate; height and weight • Date and time for the vital sign observation • Status for vital sign – complete; preliminary • The value of the vital sign – units of measure • Interpretation of vital sign – normal; abnormal, high • Reference range for the vital sign • Historically pertinent and current signs • Baseline and relevant trends	• None
Functional Status	Contains information on the "normal functioning" of the patient at the time the record is created. States when deviation from normal and limitations and improvements.	• Ambulatory ability • Mental status or competency • Daily activities – bathing; dressing; feeding; grooming • Living situation with effect on health status of patient • Social activity • Occupation activities related to working, housework • Communication ability - issues with speech; writing; cognition required for communication • Perception, including sight, hearing, taste, skin sensation, kinesthetic sense, sense of smell,	• None

Description		Represented in CCD	Represented in Claims
		balance	
Test Results	Data about current and historical test results from laboratory or other diagnostic testing performed and includes the results of observations and other procedures.	• A result ID and type to identify the specific result • Date and time for the observation • Status of the result – complete; preliminary • Value of the result, including units of measure • Interpretation of the result - normal; abnormal, high • Reference rant for the observation	• None
Encounters	List and describe any healthcare encounters pertinent to the patient's current health status or health history.	• Location where encounter is to be or was performed • Duration of encounter • Type of encounter appointment; Inpatient; ambulatory; emergency • Indicator appointment needs to be scheduled • Narrative text describing the encounter	• Location where encounter was performed • Duration of encounter (if hospital inpatient # of days)
Plan of Care	Contains all active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current and ongoing care of the patient.	• Pending orders, interventions, encounters, referrals, services and procedures • Goals for patient health care improvements • Clinical reminders - disease prevention; disease management; patient safety;	• None